DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Disability and Elder Services
DDE-445 (08/01/06)

STATE OF WISCONSIN

INDIVIDUAL SERVICE PLAN – MEDICAID WAIVERS

1 Waiver Program	1a Plan Type (Check ALL That Apply)	2 Medicaid ID Number
☐ CIP II ☐ COP-W ☐ CIP 1A ☐ CIP 1B ☐ BIW ☐ COR ☐ CLTS DD ☐ CLTS MH ☐ CLTS PD	☐ New ☐ Six Month Review ☐ Annual Recertification ☐ CLTS Crisis ☐ Update ☐ CLTS Pilot	

3 Individual's Name	4 Address (street)	4a City, State	4b Zip Code

5 Mailing Address (If Different)	6 Telephone	7 E-Mail	8 Service Plan Development Date	9 Functional Screen Date

10 Cost Share Amount	11 Level of Care	12 Parental Fee (If Applicable)	13 Personal Discretionary Funds Available	14 [Reserved]	15 Start Up/One-Time Cost -Total	16 Waiver Cost/Day Total

17 Prior Living Arrangement-HSRS Code	18 Prior Living Arrangement-Name/Type	19 Current Living Arrangement-HSRS Code	20 Current Living Arrangement-Name/Type

21 Waiver Agency	22 Agency Telephone No.	23 Support & Service Coordinator/Care Manager (SSC/CM)	24 SSC/CM Telephone No./Ext.

25 Mailing Address (Agency)	City	State	Zip	26 Mailing Address (SSC/CM)

27 E-mail Address (Agency)	28 E-mail Address (SSC/CM)

29 Name – Parent(s) or Guardian	30 Telephone No. (Home)	31 Telephone No. (Work)

32 Mailing Address (Street/PO Box)	33 City	34 State	35 Zip

36 E-mail Address	37 Telephone No. (Cell)

IN CASE OF EMERGENCY, NOTIFY: 38 Name	39 Telephone No. (Home)	40 Telephone No. (Work)

41 Address	42 City	43 State	44 Zip	45 Relationship

62 Service Code #	63 Service Name	64 Outcome No. (DDE-445a #5)	65 Service Provider Name Address and Telephone No. (E-mail, cell phone no., if known)	65a Start Date	65b End Date	66 Unit Cost ($/hr; day)	67 Authorized Units of Service and Frequency (#/day or week or month)	68 Daily Cost (total yearly ÷ 365 days)	69 Funding Source

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☐ I have been informed that I have a choice between an ICF-MR or nursing home (dependent on waiver type) and community services through a Medicaid Home and Community Waiver Program.

☐ I have been informed of and understand my choices in the waiver programs, including approval or rejection of the services and providers listed on this service plan.

☐ I have been informed of and understand my rights and responsibilities in the Medicaid Home and Community Waiver Programs.

☐ I was informed verbally and in writing of my rights and responsibilities.

☐ By my signature below I indicate I have chosen to accept community services through a Medicaid Home and Community Waiver Program.

SIGNATURE - Participant	Date Signed	**SIGNATURE –** Support and Service Coordinator/Care Manager	Date Signed
SIGNATURE – Guardian/Authorized Representative/Parent	Date Signed	**SIGNATURE -** Guardian/Authorized Representative/Parent	Date Signed
SIGNATURE - Witness	Date Signed	**SIGNATURE –** Witness	Date Signed

Distribution: DHFS, County Care Manager/Support and Service Coordinator, Individual, Authorized Representative